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ALBANY MEDICAL ANNALS

Journal of the Alumni Association of the
Albany Medical College

DECEMBER, 1917

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ALBANY MEDICAL ANNALS

Journal of the Alumni Association of the Albany Medical College

ALUMNI COMMITTEE

A. VANDER VEER, M. D. W. G. TUCKER, M. D. ANDREW MACFARLANE, M. D

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VOL. XXXVIII DECEMBER, 1917 No. 12

ALBANY MEDICAL ANNALS

Original Communications

RECOVERY FROM A SEVERE CASE OF BICHLORID OF MERCURY POISONING.

BY CHARLES ABEL HOWLAND, M. D.,
Schenectady, New York.

In the April, 1917, number of the *Journal of Laboratory and Clinical Medicine* there appeared an article entitled "Calcium Sulphid as the Chemical Antidote for Mercuric Chlorid Poisoning With Experiments and Case Reports." The author of this original article is J. H. Wilms, M. D., of Cincinnati, Ohio. The reading of this interesting article prompted me to treat my patient as Dr. Wilms suggested.

A detailed case history would not, in the case to be reported, be pertinent or add to the report, so it will be omitted. The patient was a divorced white woman of 25, a waitress, slightly alcoholic, having a positive Wassermann, and gave history of gonorrhœal infection four years ago; never pregnant, no insanity in family. She was of good physique and well nourished. I was called to see this patient, who had swallowed three seven-and-a-half grain mercuric chlorid tablets, November 25, 1916, at 1.45 A. M. I found her on the bed with eyes closed, breathing quickly, semi-conscious, eyes and face congested. There was difficulty in arousing her to obtain answers. By the bed-side was a vessel two-thirds full of vomitus in which on examination no undissolved tablets were found. The young man who called me, stated that a half hour before I reached her, she had taken three seven-and-a-half grain bichlorid tablets and had not vomited for at least twenty minutes afterwards. The patient later confirmed this statement and added that an hour before taking the poison, she had drunk three gin-

fizzes. She had then returned to her room undoubtedly more or less intoxicated.

The patient reached the Ellis Hospital at 2 A. M. The chronological hospital notes follow:

May 25, 1917, 2 P. M. Patient taken to Out-Patient Department; stomach washed out twice with two quarts of water. Patient made to drink five glasses of water and given hypodermic of one-tenth grain apomorphine; vomited in five minutes; given soap-suds enema with liquid return. Went to toilet twice to make water. Taken to her room at 2:45 A. M. and the following orders were given: milk and white of egg at least once in two hours; water to be forced; russian oil, four ounces, every two hours; calcium lactate, fifteen grains in one dose. At 5 A. M. bowels moved. The patient vomited all water, milk and egg and medication until 6:30 A. M. Vomited considerable blood mixed with milk curds. 7 A. M. Patient states she feels pretty good. 8 A. M. Temperature, 98.4°; pulse, 112; respiration, 24. 9:15 A. M. Voided water eight ounces. 10 A. M. Taken to Out-Patient Department, where an intravenous injection, gravity method, of eight ounces of sterile water solution containing one grain to an ounce of calcium sulphid was given. Four ounces of the same solution were given by mouth. One grain of calcium sulphid by mouth every two hours was ordered. 11 A. M. Urine, twelve ounces. 12 M. Temperature, 98.4°; pulse, 84; respiration, 20. 3 P. M. Good stool. 4 P. M. Nauseated. 7 P. M. Voided one pint; retaining milk; sore and tender over abdomen. 8 P. M. Temperature, 98.3°; pulse, 84; respirations, 20. Patient does not complain. 12 P. M. Temperature, 98°; pulse, 88; respiration, 20. Complains of pain in head. Laboratory findings at hospital: May 25: urine: color, pale; reaction, acid; specific gravity, 1.010; albumen, present; sugar, negative; slightly cloudy; sediment, moderate in amount; microscopic: many squamous cells and a few leucocytes, numerous hyaline and finely granular casts; rarely a cast has a renal cell adherent. (Dr. STONE.)

May 26, 7 A. M. Marked salivation and some stomatitis; temperature, 99°; pulse, 92; respirations, 24; urine, ounces, 14. 10 A. M. Water, ounces, 3; complains of sore gums; blood pressure, 110; systolic diastolic, 85. 12 M.. Temperature, 99°; pulse, 88; respirations, 20; saline enema, two quarts; returns slightly colored—retained a pint. 4 P. M. Temperature, 98°; pulse, 72; respirations, 18; urine, ounces, 16; seems better. 6:30 P. M. Urine, one quart; small amount of greenish discharge in stool. 8 P. M. Temperature, 98°; pulse, 76; respirations, 18; urine, q. s.; comfortable. 12 P. M. *Sleeping.*

Laboratory note on blood. May 26. Haemoglobin, 98, Sahli; reds, 4,800,000; leucocytes, 16,200; differential, 200 cells; polymorphonuclears, 78; lymphocytes, 8; basophiles, 0; large mononuclears, 13; eosinophile, 10. Red corpuscles not noteworthy.—(Dr. STONE.)

May 27, 1 A. M. Urine, ounces, 8. 2 A. M. Urine, q. s. 7 A. M. Slept well. 8 A. M. Temperature, 98°; pulse, 104; respirations, 20. 12 M. Temperature, 98.3°; pulse, 72; respirations, 18; light brown liquid stool. 2 P. M. Stools contained blood. 4 P. M. Temperature, 98.8°; pulse, 88; respirations, 16. 6 P. M. Urine, ounces, 8; 8 P. M. Temperature, 98°; pulse, 88; respirations, 20. 12, 2, 4 o'clock, sleeping; mouth sore. 6 A. M. Slept well. Urine: no albumen, no sugar, very few casts.

May 28. Liquid petrolatum discontinued. 8 A. M. Temperature, 98°; pulse, 94; respirations, 20; urine, ounces, 14; calcium sulphid, one grain to an ounce of water to wash mouth ordered. 12 M. Temperature, 98.2°; pulse, 22; respirations, 20; blood for Wassermann taken; was positive. 4 P. M. Temperature, 98°; pulse, 72; respirations, 20; comfortable. 2 A. M. Urine, ounces, 12. 6 A. M. Slept well.

May 29, A. M. Temperature, 98°; pulse, 88; respirations, 24; soft diet with caution; vomited. 12 M. Good defecation, large, dark brown. 4 P. M. Temperature, 97.4°; pulse, 74; respirations, 22; discharged.

May 30. At home sitting up; had bad night; ate too much; severe pain in pit of stomach; vomited twice or three times; temperature, 98.8°; pulse, 66; respirations, 18; calcium sulphid, grain, 1, continued every two hours; flower of sulphur and molasses given; sodium phosphate, 2 grains, in A. M.; liquid diet; metallic taste complained of.

May 31. Temperature, 98°; pulse, 72; respirations, 16; feeling better; still pain in epigastrium; vomited; vomitus showed blood; benzidine test; urine, specific gravity, 1.021, acid, clear, no sugar, no albumen, few granular casts and red blood cells; feels weak; looks tired; bowels moved twice in twenty-four hours.

May 31. Blood pressure: systolic, 100; diastolic, 90; the urine tested by method of Vogel and Lee for mercury, showed a very slight amount present. There is a substernal pain that is persistent and made worse by swallowing semi-solids; there is considerable eructation. Liquid diet, lime water every two hours; sodium phosphate, three drachms daily.

Meyer and Gottlieb state: "The excretion of mercury in the urine offers a means of estimating the amount of mercury circulating in the body and the duration of its action. While after absorption mercury circulates about in the body as a compound of mercury albuminate and sodium chlorid, and is chiefly excreted in the faeces and to only a small extent in the urine, still that portion of the mercury which is present in the general circulation, and which passes through the renal vessels, probably maintains a definite ratio to the amount excreted in the urine. The more rapidly the mercury appears in the urine after its administration in the given method the more

rapidly and intensely are its effects produced, and the more rapidly its elimination by this channel diminishes the more rapidly does its action in the body pass off. Always, however, it continues to be excreted for months, and, under certain circumstances, after the urine has become free from mercury, it may appear in it again, both of these facts proving that mercury is stored up in different organs, as a result of which poisoning must sooner or later result if the elimination fails to keep pace with the absorption."

June 2. No distress with liquids, but after taking soft boiled egg and bread, vomited. Some headache. One sore spot on gum and one on hard palate. Urine examination negative. Blood analysis: Reds, 4,112,000; whites, 4,000; differential, polymorphonuclears, 60; lymphocytes, small and large, 35; eosinophiles, 5; haemoglobin, 95 per cent; renal function, phthalein, 55 per cent.

June 5. Constant headache; bad taste has disappeared; some pain over epigastrium after eating; blood pressure, systolic, 110; diastolic, 82; temperature, 98.6°; pulse, 78; urine, normal.

July 9. Some pain in epigastrium and headache, but growing less each day.

August 1. Patient apparently normal.

Most readers will not have access to the article referred to in the *Journal of Laboratory and Clinical Medicine.* The following is a brief resumé and epitome:

$$CaS + Hg\ Cl_2 = Ca\ Cl_2 + HgS$$

Mercuric sulphid and calcium chlorid are two almost inert chemical compounds.

Experiments with feeding seven dogs very hard insoluble $Hg\ Cl_2$ tablets showed they gave an average solubility in the stomach of six grains $Hg.\ Cl_2$ in from five to six minutes. Three dogs were given 7.3 grains of $Hg\ Cl_2$ and no antidote. In a few minutes three to five of the dogs vomited blood stained mucus. *Exp. I:* Dog lived 4 days. *Exp. II:* Dog lived 3 days *Exp. III:* Dog killed on 4th day. *Exp.* A dog was placed in a cage soiled with vomitus, where a dog poisoned by $Hg\ Cl_2$ had been and was thus poisoned, causing death of the dog in six days. *Exp. II:* Dog fed by mouth solution 7.5 grains bichlorid with 7.5 grains calcium sulphid; no effect; dog well.

Then follow *Exp. V, VI, VII,* and *VIII,* in which dogs were

given 7.3 grains bichlorid with the prompt vomiting, rectal tenesmus, bloody diarrhœa, etc. *Exp. V* allowed the dog to go forty-eight hours; *Exp. VI,* also forty-eight hours; *Exp. VII,* seventy-two hours; *Exp. VIII,* forty-eight hours before calcium sulphid was administered intravenously. Dogs in *Exp. VII* and *VIII* died due to calcium sulphid being poor. *Exp. V* and *VI* showed the dogs to recover promptly from marked poisoning after receiving treatment and their postmortems showed their organs practically normal. Dog of *Exp. IX* after forty-eight hours, recovered. Dog of *Exp. X,* six hours antidote (CaS) in oil, recovered.

The postmortem on these dogs showed: Intestines were red and inflamed; stomach contained a thick coffee-colored fluid; a round ulcer about one centimeter in diameter was found on the anterior surface near the pylorus; submucous clot-like masses were found about the pylorus, varying in size from two to five millimeters in diameter; the duodenum was red and inflamed; bile, thick and gritty; the kidney cortex was red and streaked; the medulla nephrica was congested, proportion of cortex one to medulla three; red fluid in the calices. Chest: Both lungs hepatized. Heart: Ulcer on the visceral layer of the pericardium over the terminals of the coronary vessels; pericardium thickened; myocardium inflamed; musculi pectinati markedly inflamed; subendocardial ecchymoses in both ventricles. Esophagus inflamed."

Mr. Frank Maltaner, M. A., after duplicating these experiments, using rabbits instead of dogs, draws conclusions:

"The value of the antidote probably lies in the formation of the relatively insoluble, double salt, mercuric sulphid mercuric chlorid ($HgS.\ HgCl_2$) and the very insoluble mercuric sulphid.

"Both of these substances are formed in the test tubes, the formation of the insoluble sulphid depending upon the excess of calcium sulphid used."

Case Reports

A considerable number of cases of human beings cited where the administration of calcium sulphid by mouth (one grain to three grains every two hours) after the taking of bichlorid was

followed by recovery. Also cases were reported of recovery after the intravenous administration of calcium sulphid.

Summary and Conclusions of Article

"In advanced cases of mercuric chlorid poisoning the intravenous method of injecting calcium sulphid solution grain for grain of the bichlorid of mercury taken, is the safest and most rapid. An advantage of the intravenous method lies in the assurance that the patient receives the required amount of the antidote, and that it is more direct. Calcium sulphid may also be administered by mouth when the intravenous method is not practicable. When the discomfort or the condition of the patient warrants it, both methods may be used. The use of calcium sulphid by mouth may be continued till all symptoms of mercuralism have disappeared, since it is nontoxic. Recovery has taken place, when the antidote was administered by mouth, as late as twelve hours after taking 7.5 grains of bichlorid of mercury, and thirty hours when administered intravenously.

"The minimum lethal dose of bichlorid of mercury in the human being is one decigram. (Barbour.)

"The calcium sulphid solution must be freshly prepared for intravenous exhibition or it loses its sulphur and becomes ineffective. Calcium sulphid solution should not be used stronger than one grain to the ounce of water. The solution should be boiled and filtered through cotton. It should preferably be given in the median basilic or the median cephalic vein.

"Calcium sulphid is the quickest, simplest and surest antidote for mercurial poisoning used at the present time. It has been proved clinically and in the laboratory.

"Experiments showed that mercuric chlorid poisoning produced a wide pathologenesis notably, gastritis, ulcer of the stomach, hepatitis, duodenitis endocarditis, ulcerative pericarditis, pneumonitis, tubular nephritis (which is manifested by complete suppression of the urine) and a number of other very marked pathological changes, microscopically and macroscopically manifested. All these tissue changes become normal with the exhibition of one dose of calcium sulphid in solution intravenously grain for grain of poison taken.

"When given by mouth, it should be administered in the tablet or crude drug form, in two to five grain doses every hour, until an excessive amount is taken. A grain is four times the amount of calcium sulphid necessary to neutralize mercuric chlorid in the test tube.

"The calcium sulphid solution, if deteriorated, will produce severe convulsions owing to the free action of calcium on the spinal cord, hence the necessity of a fresh solution. Another danger is the possibility in deteriorated solutions, of hydrogen sulphid which is a fatal poison being present.

"Local antidoting in the stomach by the use of whites of eggs and lavage with large quantities of water is useless; bichlorid of mercury is so rapidly absorbed from the stomach that very little remains in the stomach unabsorbed at the end of five minutes. The vomiting, by this time, is so profuse that if any free bichlorid of mercury were still present in the stomach, it would not remain long enough to cause further damage.

"These experiments on dogs can not be regarded as conclusions. There is a difference between test-tube chemistry and that of human metabolism.

"The possibility that calcium sulphid may act as a real cure in such cases of bichlorid poisoning must be investigated more thoroughly. No harm can come."

In this case reported by me, there are some interesting speculative considerations:

(1) Did she take over twenty-one grains of bichlorid? Severe epigastric pain, vomiting of blood, blood in stools, mercury in urine, immediate symptoms of kidney irritation, stomatitis and salivation would go to prove she must have taken at least a considerable amount.

(2) What part did stomach lavage, enema, liquid petrolatum, egg-albumen and milk play in her recovery, if any? These same things have repeatedly failed in other cases.

(3) Did the fact that her stomach and digestive tract had been deranged in absorptive power by alcohol, have any influence?

(4) Did the fact that she was an active syphilitic, mean anything?

Six weeks after I discharged this patient from the bichlorid

poisoning I saw her with very numerous active secondary syphilitic lesions. The overwhelming dose of mercury did not prevent the syphilis continuing its usual course.

Attention is called to the interesting reports of experiments on the value of phosphite and hypophosphite combinations as antidotes in mercuric chlorid poisoning as published in the *Journal of Laboratory and Clinical Medicine* by Bernard Fantus, M. D., and Emory G. Hyatt of Chicago.

APLASTIC ANEMIA.

From the Medical Service of the Albany Hospital, Fourth Year Student Section Work,—Albany Medical College

By HYMAN HERSHBERG, M. D.,

New York City.

History.—Ehrlich in 1888 described a typical case of aplastic anemia. Since then isolated cases have been reported abroad and in this country.

Etiology.—Block, Kelly and Ziegler think "aplastic anemia" is a primary inherent diathesis or a developed asthenic condition of the bone marrow. Türk thinks it is a hypoplasia of the vascular system because as a result of the investigations of the Neisser Klinik it was agreed that there is an internal relationship between the development of the vascular system and marrow tissue. In the reported cases we find the following causes: angina with abscess formation, severe dermatitis, puerperal septicaemia, pernicious anemia with severe hemorrhages, buccal periostitis, mouth trouble, ulceration of the throat, measles, whooping cough, pneumonia and hereditary syphilis. Experimentally this disease has been reproduced in dogs and rabbits. Blumenthal and Morawitz have shown that continuous withdrawal of blood from dogs and rabbits produces disappearance of erythroblastic and myeloblastic tissues and causes increase in the lymphoid elements. It produces changes in the bone

marrow that have a relationship with those of aplastic anemia in man. The presence of iron pigment in different organs and especially in the liver at the autopsy demonstrates the haemolytic character of the disease.

Pathological Anatomy.—The most important changes are in the marrow of the bones. The macroscopical changes in the marrow are not uniform. Sometimes this tissue is yellow and gelatinous, *sometimes red and cellular.* In most typical cases the marrow is yellow and consists of fat.

Microscopically: Erythroblasts, myelocytes and other cells having to do with the formation of blood corpuscles are few in number or completely lacking. The number of lymphocytes is abundant. Neutrophilic myelocytes so abundant in normal red marrow are found only after careful searching here. Megaloblasts are also few in number. Numerous hemorrhages are found in the endocardium, myocardium and pericardium, in the pleural sac, hemorrhages in the cerebral hemispheres, so pachymeningitis haemorrhagica interna and bleeding in the ovaries.

Pathogeny.—The marrow is so extensively diseased that it cannot perform its functions or it fails to do so in spite of the usual stimulus. The inability of the marrow to respond explains why the cases progress so rapidly and why the characteristic blood picture develops. The blood picture is the result of hemocytolysis or of the failure of regeneration of the bone marrow, which may be caused by a simple deficiency of the regenerative powers. An inhibitive action of the bone marrow may be caused by the same factors that produce the destruction of the blood elements.

Kleinschmidt believes that not the constitution of the organism but a toxin causes the disease. It is an injurious agent which acts not only as an haemolytic agent, but also on the bone marrow which is unable to resist.

Symptomatology.—The disease may last from six to nine months. Generally it is a rapidly fatal disease. The disease is usually of a gradual onset. The patient becomes weaker from day to day. The asthenia is very marked after a short time. The patient complains of intense headaches, thirst and loss of appetite. Nausea and vomiting may become persistent. Fever, a temperature from 100°-103°. Pulse is small. In most of the

cases the loss of weight is marked. With the progress of the disease the patient becomes apathetic and depressed.

Physical examination shows a slight enlargement of the liver. The spleen may be palpable, there may be also a slight enlargement of the lymph glands. Most striking are the numerous hemorrhages in the skin, mucous membranes and internal organs. Death is due to the great destruction of blood and lack of resistance.

Treatment.—Iron, arsenic, sodium cacodylate and blood transfusions are without any help. The disease takes always a rapid, malignant and fatal issue.

PATIENT: M. E.—Age, 16; white, female, entered the Albany Hospital, November 14, 1915, unable to complain of anything. From the family physician and from some of her relatives the following history was obtained:

The family physician writes the following:

"I can safely say that during thirty years of practice in both city and country it was the most peculiar case I ever saw, and I was unable to make a diagnosis. As to the family history: the father is living in good health and the mother died suddenly of cerebral hemorrhage. She was a powerful and healthy looking woman and mother of a large number of children.

"I saw the patient some time during November, 1915, and made two or three visits, and as the family with whom she was living could not take care of her, I sent her to the hospital. When I first saw her, I was surprised at the extreme degree of anemia and exhaustion. She had slight fever, from 101° to 102°, and a rapid pulse from 90 to 120. The degree of weakness was such that I gave an unfavorable prognosis and felt that the patient only had a few days to live. If I remember correctly she was ill about two weeks.

"The mouth had the appearance of stomatitis and the breath was very foul. There was no evidence of any throat trouble. I thought of a possible diabetic condition, but found the urine negative. There was no evidence of a tubercular condition. To make sure that there was no typhoid, I had Widal test made which was negative. I made a probable diagnosis of pernicious anemia due to some toxic condition. Purpura was the last thing I would have expected as there were no external evidences."

Physical Examination.—The patient is a young girl apparently slightly deaf. She is conscious and rational. There is a strikingly pale color of the skin and mucus membranes and there are blood crusts about the nose, lips and gums. The mouth is opened with difficulty and shows extreme

pallor of the entire oral cavity. Pupils react to light and accommodation. Occular movements are normal. There is no discharge from the ears. Superficial glands are not enlarged.

Thorax is symmetrical; costal angle is 90. The clavicles are not prominent, the type of breathing is costo-abdominal. The movements of the two sides are equal. There are no visible pulsations.

Lungs.—The breath sounds are harsh. There are a few crackling râles posteriorly in the subscapular regions.

Heart.—The cardiac dullness is 8 c. m. to the left and 3 c. m. to the right of the mid-sternal line. There is a systolic murmur at the apex. It is not transmitted and there is a systolic (haemic) murmur at the base of the cardiac area.

Liver.—The dulness extends from the fourth rib to the costal margin.

Spleen is not palpable and is not enlarged to percussion.

Extremities.—There is very slight puffiness at the feet.

Nervous System.—The knee jerks and tendo-achillis are preserved. There is no Babinsky or Oppenheim. The tendon reflexes in the upper extremities are preserved. The organic reflexes are not involved.

The most important physical signs in this patient are the blood clots on the upper and lower lips, the tongue and the right tonsils; also about the nose. There are small ecchymoses in the first interspace (right side) and over the sternum at the level of the third rib, on the anterior superior spines, on the thighs and tibias.

Temperature.—97.5°-103°.

Pulse.—120-160.

Respirations.—30-55.

Laboratory Finding.—Urine.—Sp. gr. 1.020; color, amber; albumin, negative; sugar, negative; bile, negative; microscopic, negative.

Stool Examination.—Negative for blood by guaiac test; microscope, negative.

Blood.—November 15, 1915, white blood cells, 800. Second examination of the blood on the same day was made: white blood cells, 1,200; red blood cells, 1,400,000; haemoglobin, 10 per cent.

Differential Count.—Small lymphocytes, 81 per cent; large lymphocytes, 7 per cent; polymorphonuclear neutrophiles, 12 per cent; no eosinophiles, no blood platelets,* no nucleated red cells, no normoblasts or megaloblasts; no polychromatophylia.

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* I believe that the absence of the blood platelets and the marked decrease in the leukocytes explain the great retardation in the coagulation of the blood drops, because it seems definitely proved that the blood platelets and leukocytes are the chief source of the coagulation power of the blood.

From November 14th to November 17th the patient became progressively worse. An attempt was made to perform a blood transfusion, but the patient died (on November 17th) before this could be accomplished.

Post Mortem Examination performed at the Albany Hospital, November 17, 1915, for Dr. Ordway by Dr. Kellert.

M. E.—Age, 16 years. Fourteen hours post mortem.

The body is that of a well developed, somewhat emaciated white young woman. Rigor mortis is present. There is slight post mortem lividity in the dependent portions. Oedema is absent. The pupils are mid-wide, the right is somewhat smaller than the left. Pale bloody fluid is seen about the nostrils and the mouth. The teeth are in poor condition and covered with sordes. The border of the lips shows several small deep red areas. Scattered over the entire body, particularly about the extremities and the bend of the left elbow, are numerous minute petechial areas not elevated and not surrounded by any discoloration. On the external surface of the left leg beneath the knee is a small area of subcutaneous hemorrhage. There is no enlargement of superficial lymph nodes.

Peritoneal Cavity.—The abdominal wall contains a slight amount of fat, bright yellow in color. The abdominal muscles are abnormally reddened. The peritoneal surfaces appear smooth and glistening. No free fluid is present. The appendix is approximately 10 c. m. in length and lies retrocœcal.

Pleural Cavities.—The surfaces are normally smooth, moist and glistening. In the left pleural cavity there is found about 50 c. c. of amber colored turbid fluid and a small fibrinous clot. The right pleural cavity is negative.

Lungs.—They are somewhat voluminous. Crepitation is present throughout but diminished in the lower lobes. The upper lobe of each lung presents an occasional subpleural hemorrhage of variable size. Similar areas are more numerous in the lower lobes on each side, coalescing and forming large areas of bluish discoloration. These lobes have a distinctly pebbly feel, and on cross section numerous areas of consolidation are found. These areas are firm and sharply circumscribed. Cut surface projects slightly and has a distinctly granular appearance. A moderate amount of bloody fluid escapes on section.

Pericardial Cavity.—It contains approximately 100 c. c. of amber colored fluid, and an elongated fibrinous clot is adherent to the anterior surface of the heart. The surfaces are smooth.

Heart.—It weighs 205 grams. The cavities present no dilatation. The epicardium presents several small bright red areas, apparently hemorrhages, which extend into the myocardium. In the right ventricle these areas communicate with similar areas in the endocardium. The myocardium is very pale and shows a tendency toward mottling which is well

marked in the papillary muscles. The endocardium appears normal, except for the reddish areas. The valves are negative. On the external surface of the heart one of the reddened areas shows a yellowish-white center.

Spleen.—It weighs 180 grams. The capsule is bluish-red in color and smooth. To the lower pole is attached a firm adhesion. The splenic notch is well marked. It is firm in consistency and its cut surface is negative. Surface scrapings are normal in amount.

Liver.—Weight, 1,275 grams. It is pale brown in color and firm in consistence. The surface is smooth. Cut surface is also pale brown in color and the hepatic markings are slightly obscured. The gall bladder is somewhat contracted, otherwise negative.

Pancreas.—It is normal in size and consistency. It is pale white in color.

Kidneys.—Combined weight, 290 grams. They are exceedingly pale. There is a moderate amount of perinephritic fat present. The capsule strips readily, exposing a smooth surface. The lower pole of each kidney presents a marked dilatation of the cortical veins and an occasional minute hemorrhage is seen beneath the capsule. On cut section the pyramids and cortex are prominent, but very pale. The pelvis of the left kidney shows a small accumulation of turbid fluid. The mucosa appears normal.

Adrenals.—They are normal in size and shape and present alternating yellowish and grayish areas.

Gastro-Intestinal Tract.—The stomach is slightly dilated and contains from 300 to 400 c. c. of fluid. The mucosa is extremely pale and only an occasional reddened area is found. The duodenum is slightly dilated, the jejunum is negative, the ileum also appears normal, the solitary follicles and Peyer's patches are prominent, but no evidence of inflammation or ulceration can be found.

The mucosa appears normal. The large intestine is also negative. There is no evidence here or in the sigmoid or colon of submucous hemorrhages. The foetal material in the large intestine is bright yellow in color. The lymph nodes of the mesentery are slghtly enlarged and reddened. Throughout the mesentery, particularly along the intestinal attachment are numerous small grayish-black rounded areas suggesting pigment or collections of lymphoid tissue.

Genital Organs.—External genitalia, negative. The uterus and tubes are normal; the bladder is negative.

Aorta.—It is normally smooth and elastic, but the diameter appears to be slightly diminished. Very little blood is present in the vascular system and the fluid which is found is very pale.

Bone Marrow.—The marrow of the right femur is *bright red in the upper third, pale red in the middle and very dark red in the lower third.*

No evidence of fatty marrow is found. The marrow in the upper portion of the femur is firm in consistency.

Organs of the Neck.—Not done.

Head.—Not done.

Bacteriology.—Cultures from heart's blood yield Gram-negative bacilli and streptococci.

Smears from Bone Marrow show Gram-positive cocci in pairs, Gram-negative bacilli and short thick Gram-positive bacilli. Cultures show streptococci and Gram-negative bacilli. Cultures from pericardial cavity and pelvis of kidney yield streptococci and Gram-negative bacilli. Cultures from lung show streptococci, staphylococci, pyogenes aureus and bacillus aerogenes capsulatus. (Probably represent terminal infection due to lowered resistance as well as post-mortem invasion from gastro-intestinal tract.)

Microscopical examination of the numerous sections of the bone marrow showed that myelocytes, erythroblasts, megaloblasts and especially the neutrophilic myelocytes are few in number, but the number of lymphocytes was abundant.

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Editorial

> Although only an amateur in medicine, he was invited by the physicians to attend the meetings of their club, and it was of this club that he told the story that the question was once raised whether physicians had, on the whole, done more good than harm. After a long debate, Sir John Pringle, the president, was asked to give his opinion, and replied that if by physicians they meant to include old women, he thought they had done more good than harm; otherwise more harm than good.
>
> *The True Benjamin Franklin.* SIDNEY GEORGE FISHER.

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The Alumni Association

The perennial task of arranging the meeting of the Alumni Association may easily fall into the simple duty of preparing a routine program. The occasion is always enjoyable, even when very simple plans are adopted. But times and customs change, and events bring about conditions which demand recognition. This is the situation in the college at present. Reorganization of its administration has been effected, and it is now, after two years of trial, firmly established. Participation in military service has revealed the capability and patriotism of a large number of alumni, which will become all the more patent when the ratios of enlistments of the various colleges are computed. Laboratory and hospital advantages are being correlated with the college teaching upon lines long laid out but never more effectively accomplished.

The Executive Committee has taken notice of all these facts, and under the energetic direction of Dr. Lamb, President of the Association, has determined upon an alumni reunion next June, which shall represent the activities of an institution of high grade, and demonstrate the pride and fellowship of its graduates. Two meetings of the Committee have been held, and after full discussion a general outline of the next anniversary has been determined. The tentative program, subject to such modification as becomes necessary, has been adopted, and the following recommendations, subject to necessary changes, are proposed:

1st. That the alumni reunion be held the day following commencement at Union College;

2nd. That, provided the Union Commencement and the Medical Commencement are identical, the following program be adopted:

a. General assembly of alumni in the College at 9 A. M.
b. Association Meeting at 10 A. M.
c. Demonstrations at the College, 11:30 A. M. to 1 P. M.
d. Luncheon at Country Club, 1 P. M. Automobiles to be provided.
e. Clinics at Albany Hospital, 3 to 5 P. M.
f. Lawn party at Albany Hospital, 5 P. M.
g. Association dinner, Hotel Ten Eyck, 8 P. M.

It is further recommended:

That the ANNALS is officially recognized as the medium of communication between the members of the Association themselves and between them and the College;

That the Executive Committee emphasize the importance of the ANNALS as the representative publication of the Association and of the College, and urge the better and more general support of the ANNALS by the Association.

That it is particularly important at this crisis that the activities of the alumni in military service be recorded in the ANNALS and that every effort be made to secure this record;

That through the ANNALS an energetic effort be made to arouse the interest of alumni in commencement; and to publish from time to time such information as will promote the success of the commencement meetings.

It is finally recommended:

That the president be requested to issue a circular letter to the alumni, outlining the purposes of this committee, and asking support for the ANNALS and for the Association.

It is believed that the members of the Association will receive the announcement of these innovations with pleasure, and will accept, in so far as their engagements will permit, the opportunity for a day of scientific and social pleasure.

Public Health

Edited by Arthur Sautter, M. D.

DEPARTMENT OF PUBLIC SAFETY, BUREAU OF HEALTH, ALBANY, N. Y.

BUREAU OF VITAL STATISTICS.

COMPILED BY WILLIAM F. FULLGRAFF, REGISTRAR.

DEATHS FOR MONTH OF OCTOBER, 1917.

Consumption	8	Broncho pneumonia	7
Typhoid fever	0	Bright's disease	9
Scarlet fever	0	Apoplexy	11
Measles	0	Cancer	17
Whooping cough	1	Accidents and violence	14
Grippe	0	Deaths under 1 year	13
Diarrheal diseases	7	Deaths over 70 years	38
Diphtheria and croup	2	Death rate	15.30
Pneumonia	4	Death rate less non-residents	12.41

Deaths in Institutions.

	Non-res.	Res.		Non-res.	Res.
Albany Hospital	9	11	Infants' Home	0	2
Albany Hospital Camp	3	0	Maternity Hospital	0	2
Homeopathic Hospital	5	1	St. Margaret's House	4	0
St. Peter's Hospital	2	8	Home for the Aged	1	1
Central Federation Pavilion	1	0	Home for the Friendless	1	1
Hospital for Incurables	4	1	Dominican Convent	0	2
Albany County Hospital	1	0	Public places	0	3
				31	32

Births	194	Still births	6

BUREAU OF COMMUNICABLE DISEASE.

Cases reported during October, 1917.

Typhoid fever	13	Measles	3
Scarlet fever	6	Whooping-cough	9
Diphtheria and croup	12	Tuberculosis	33
Chickenpox	25	Ophthalmia neonatorum	1
Smallpox	1		
		Total	103

Number of days quarantine for diphtheria:

Longest..... 10 Shortest..... 10 Average..... 10

Number of days quarantine for scarlet fever:
Longest..... 32 Shortest..... 32 Average..... 32
Fumigations: Houses..... 23 Rooms..... 138
Milk bottles disinfected 40

Communicable Disease in Relation to Schools.

	Reported D.	S.F.	M.	Deaths D.	S.F.	M
Public School No. 4		1				
Public School No. 20	1					
St. Joseph's Academy	1	1				
Cathedral School	1					

NURSES' REPORT.

Tuberculosis.

Living cases on record October 1, 1917		781
Cases reported:		
By card	31	
Dead cases by certificate	2	33
		814
Dead cases previously reported	6	
Dead cases not previously reported	2	
Removed	2	
Died out of town	1	11
Living cases on record Nov. 1, 1917		803
Total tuberculosis death certificates		8
Non-resident deaths:		
Albany Hospital Camp	3	
C. F. L. Pavilion	1	4
Resident deaths		4

Visits to Cases of Communicable Disease.

Tuberculosis	8	Miscellaneous	39
Smallpox	2	Visits to physicians	6

BENDER LABORATORY REPORT.

Diphtheria.

Initial positive	12	Release negative	6
Initial negative	110	No growth	10
Release positive	2		
		Total	140

Sputum for Tuberculosis.

Positive	40	Negative	71
		Total	111

Widals.

Positive	13	Suspicious	7
Negative	27		
		Total	47

Milk analyses	163	Water analyses	9
Wassermann reactions	167		

Bureau of Nuisances.

Complaints made	49	Reinspections	48
Inspections	52	Plumbing	11
Plumbing	17	Sanitary	37
Sanitary	35		

Hearings.

Cases heard before Health Officer	5

Class of Cases

Plumbing	2	Filthy premises	1
Privy vault	1	Smoke	1

Disposition of Cases.

Abated	1	Reinspections	4

Bureau of Plumbing, Drainage and Ventilation.

Inspections	139	New buildings	7
Old houses	74	Houses tested	4
New houses	65	Water tests	4
Permits issued	109	Houses examined	26
Plumbing	91	Re-examined	59
Building	18	Valid	16
Plans submitted	15	Without cause	10
Old buildings	8		

Dead Animal Report.

Horses removed	16	Cats removed	261
Dogs removed	277		
		Total	554

BUREAU OF MARKETS AND MILK.

Public market inspections	15	Milk houses inspected	107
Market inspections	2	Stores inspected	76
Lactometer readings	115	Milk cans inspected	1,087
Temperature readings	115	Dairies inspected	106
Fat tests	70	Cows examined	1,362
Sediment tests	87	Dairies quarantined	1
Chemical tests	24	Peaches condemned (baskets)	7
Bacterial counts	70	Dates condemned (boxes)	8
Milk depots inspected	7		

MISCELLANEOUS.

Cards posted for communicable disease	16	from doctors	6
Cards removed	6	Inspections and reinspections	40
Notices served on schools	103	Employment certificates issued to children	38
Notices served on stores and factories	5	Vaccinations	98
Postal card returns sent to doctors	16	Cases assigned to health physicians	52
Postal card returns received		Calls made	84

Garbage collected from 1st District (bbls.)	149	District (bbls.	270
Garbage collected from 2d		Garbage collected from 3d District (bbls.)	268

Medical News

ALBANY ENLISTMENTS.—Dr. HENRY L. K. SHAW (A. M. C. '96), who has received a commission of major in the Medical Reserve Corps, and who has recently been transferred from Madison Barracks, N. Y., to Fort Oglethorpe, Ga., calls attention to the large number of physicians who have entered the service from Albany. Of the one hundred and seventy-six physicians of Albany, forty-six have received commissions and forty-one are in active service, fourteen having been rejected on account of physical disability, age or some other sufficient cause. This gives a percentage of twenty-six for all physicians, and thirty-one for members of the County Medical Society, of which one hundred and forty-eight are members, not including those whose applications were rejected.

MEDICAL SERVICE OF THE ARMY AND NAVY.—Dr. PATRICK J. HIRST (A. M. C. '10), of Ballston Spa, N. Y., has received his commission as first lieutenant in the Medical Reserve Corps, and has been ordered for

duty as a member of a board of medical officers for the special examination of tuberculosis to Camp McClellan, Anniston, Ala.

—Dr. Morris B. Beecroft (A. M. C. '13), of Albany, N. Y., has received his commission as captain in the Medical Reserve Corps, and has been ordered to Rockefeller Institute, New York City, for a course of instruction in laboratory work.

—Dr. Nathan D. Garnsey (A. M. C. '91), of Kinderhook, N. Y., has received his commission as lieutenant in the Medical Reserve Corps.

—Dr. Edward J. Callahan (A. M. C. '14), of Schuylerville, N. Y., has arrived in England for duty in France as a member of the Medical Reserve Corps.

—Dr. Charles A. Krauss (A. M. C. '16), of Troy, N. Y., has received his commission as lieutenant in the Medical Reserve Corps, and has been ordered for duty to Camp Meade, Annapolis Junction, Md.

—Dr. John C. Knapp (A. M. C. '16), of Philmont, N. Y., has received his commission as lieutenant in the Medical Reserve Corps, and has been ordered to Cornell Medical College, New York City, for a course in military roentgenology.

—Dr. Robert W. Andrews (A. M. C. '98), of Poughkeepsie, N. Y., has received his commission as major in the Medical Reserve Corps, and has been ordered for temporary duty to the Boston City Hospital for a course of instruction in fractures.

—Dr. Ray H. Humphrey (A. M. C. '13), of Union, N. Y., has received his commission as lieutenant in the Medical Reserve Corps, and has been ordered for duty to Camp Logan, Houston, Tex.

—Dr. Leo R. Tighe (A. M. C. '16), of Poughkeepsie, N. Y., has received his commission as lieutenant in the Medical Reserve Corps, and has been ordered for duty to Hospital Train No. 21.

—Dr. Richard P. Doody (A. M. C. '16), of Troy, N. Y., has received his commission as lieutenant in the Medical Reserve Corps, and has been ordered to Kelly Field, Signal Corps, Aviation School, San Antonio, Tex.

—Dr. James E. Maloney (A. M. C. '07), of Ravena, N. Y., has received his commission as captain in the Medical Reserve Corps, and is stationed at Camp Sherman, Chillicothe, Ohio.

—Dr. Waldo H. Sanford (A. M. C. '96), of New York City, has received his commission as captain in the Medical Reserve Corps, and is stationed at Louisville, Ky.

—Dr. Joseph B. Betts (A. M. C. '94), formerly senior physician and pathologist at the Buffalo State Hospital, Buffalo, N. Y., has joined Base Hospital Unit No. 23, as pathologist, and has received his commission as captain in the United States Army.

—Dr. Clinton B. Hawn (A. M. C. '06), Dr. Joseph P. O'Brien (A. M. C. '98), and Dr. Edwin L. Draper, instructor in surgery in the Albany Medical College, have been promoted from the rank of lieutenant to that of captain in the Medical Reserve Corps.

—Dr. David W. Beard (A. M. C. '14), of Cobleskill, N. Y., has received his commission as first lieutenant in the Medical Reserve Corps, and is stationed at Camp Jackson, Columbia, S. C.

—Dr. Frederic W. Loughran (A. M. C. '90), with rank of major in the Medical Reserve Corps, has been ordered for duty as instructor to Fort Oglethorpe, Ga.

—Dr. Emanuel M. Freund (A. M. C. '16), holding commission as lieutenant in the Medical Reserve Corps, is reported to have arrived safely in France.

—Dr. Harry V. Judge (A. M. C. '14), has received his commission as first lieutenant in the Medical Reserve Corps, and is stationed at the base hospital at Camp Jackson, Columbia, S. C.

Personals.—Dr. Henry F. C. Muller (A. M. C. '87), formerly of Rensselaerville, N. Y., has removed to Ravena, N. Y.

—Dr. John H. Reid (A. M. C. '04), of Troy, N. Y., was elected Recording Secretary of the New York and New England Association of Railway Surgeons at its twenty-seventh annual meeting, held at Hotel Astor, New York, on November 8, 1917.

—Dr. Joseph H. Bowers (A. M. C. '12), has resigned his position as house physician at the Brady Maternity Hospital in Albany, and will begin private practice with offices at 835 Lancaster St.

—Dr. Benjamin H. Shapiro (A. M. C. '15), has been appointed medical interne at the Brooklyn State Hospital, Brooklyn, N. Y.

—Dr. Roy L. Leak (A. M. C. '98), formerly at the St. Lawrence and Manhattan State Hospitals, and more recently in charge of the Psychopathic Hospital in Syracuse, N. Y., has been appointed Medical Director of the State Hospital for the Insane at Columbia, S. C.

—Dr. Howard M. Kenyon (A. M. C. '17), has been appointed Medical Interne at the Binghamton State Hospital, Binghamton, N. Y.

—Dr. Henry M. Chandler (A. M. C. '03), has been appointed assistant physician at the Manhattan State Hospital, Ward's Island, New York City.

—Dr. Earl C. Waterbury (A. M. C. '16), has removed from Pine Bush, N. Y., to Croton Lake, N. Y.

—Dr. Harry S. Howard (A. M. C. '13), has removed from Albany to Minaville, N. Y.

—Dr. Charles Bernstein (A. M. C. '94), publishes a paper on "The Various Phases of Feeble-Mindedness and the Stigma of Degeneration," in the *New York State Journal of Medicine* for November, 1917. Dr Bernstein's paper was the basis of a clinic and address given in a symposium on feeble-mindedness at the annual meeting of the Medical Society of the State of New York, held April 26, 1917.

—Dr. Ward W. Millias (A. M. C. '12), discussed Dr. Bernstein's paper, and his remarks are published in the *New York State Journal of Medicine* for November, 1917.

—Dr. George P. Coopernail (A. M. C. '00), of Bedford, N. Y., publishes a paper on "A Plea for More Caesarian Sections in Selected Cases: Thirty-four Consecutive Cases Without Mortality to Mother or Child," in the *Medical Record* of November 17, 1917. Dr. Coopernail's paper was presented before the Westchester County Medical Society at the September meeting, 1917.

—Dr. Theron Smith (A. M. C. '14), formerly Medical Interne at the Binghamton State Hospital, Binghamton, N. Y., has resigned to engage in practice at Sea Island City, N. J.

—Dr. James H. Van Buren (A. M. C. '05), has resigned his position as Junior Assistant Physician at the Craig Colony for Epileptics, Sonyea, N. Y.

In Memoriam

Died.—Dr. Melvin Sheldon (A. M. C. '93), died at Brooklyn, N. Y., aged 51. Dr. Sheldon was a member of the Medical Society of the State of New York, and was one time a member of the staff of the Samaritan Hospital, Brooklyn, and was also president of the Physicians' Economic League of Brooklyn. He died at his summer home in Churchtown, N. Y., October 8, 1917, from pneumonia.

—Dr. Will O. Scott (A. M. C. '91), died at Massena Springs, N. Y., on May 24, 1917, from chronic nephritis, aged 49. After graduation Dr. Scott began practice at Parish, Oswego county, N. Y., and there remained until his death. He was a member of the County and of the State Societies.

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Ἀσφαλὲς καὶ ἔμπεδον ἔστω τὸ σὸν ἔδος. Ἐκ σκότου μὲν ἔξαγε
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